

REFERRAL FORM

NOBLE AMA SELECT MEDICAL GROUP

Fax: (760) 631-1619 Phone: (877) 207-7600

Date of Referral Request: ____/____/____

APPLICABLE COPAY	AUTHORIZATION NUMBER

Blue Cross/ California Care Blue Shield Cigna Healthnet PacifiCare Universal Care Other _____

SECTION I DIRECT CAPITATED PROVIDER - NOTIFICATION ONLY - NO AUTHORIZATION NUMBER REQUIRED - SEE INSTRUCTIONS

OB/GYN (check roster for phone and fax numbers) Tel # _____ Fax # _____

SECTION II DIRECT REFERRAL - NOTIFICATION ONLY - NO AUTHORIZATION NUMBER REQUIRED - SEE INSTRUCTIONS

Specialty _____ Direct Referral Code _____

Notes:

- 1) Member's PCP must fax or mail form to IPA UM Staff and copy to Specialty Physician. Retain a copy of this form in member's chart and give a copy to Member for presentation to Specialty Physician.
- 2) This section is NOT to be used for the following: Non-Contracted Providers, Hospital In-Patient Services or Medical/Surgical Procedures.
- 3) All other services or medical procedures require pre-authorization - unless specifically allowed in the Direct Referral List.

SECTION III PRE-AUTHORIZATION REQUEST Routine Urgent Emergent Retro

COMPLLETE FORMAL REFERRAL TYPES	Patient Name (First, MI, Last)	Social Security Number	Date of Birth	Telephone #
	Address, City, State, Zip			
	Member ID			
	PCP Name	PCP TEL #	PCP FAX #	
	REFERRED FROM		REFERRED TO	
	<input type="checkbox"/> PCP Office Contact	Specialty Type		
	<input type="checkbox"/> Specialist Name Tel # _____ Fax # _____	Provider Name/Facility		1st Available <input type="checkbox"/>
	Place of Service <input type="checkbox"/> Office <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Other _____	Tel # _____ Fax # _____		
	Clinical Comments/Treatment Plan LMP _____ EDC _____			
	Diagnosis			ICD-9
Procedure/Service Requested <input type="checkbox"/> Surgical Assistant			CPT-Code	
SIGNATURE OF REFERRING PROVIDER (MANDATORY - WILL NOT BE PROCESSED WITHOUT SIGNATURE)				

FOR USE BY NOBLE AMA SELECT MEDICAL GROUP, INC. UM STAFF ONLY

<input type="checkbox"/> Authorize Date	<input type="checkbox"/> Pending Date	<input type="checkbox"/> Modified Date	<input type="checkbox"/> Denied Date	<input type="checkbox"/> Not a covered benefit.	<input type="checkbox"/> T P L

Comments/Remarks

UM Signature	Date	Date PCP Notified	Please notify member today of referral status.

Authorization does not guarantee payment or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions at the time services are rendered. This certification is good for sixty (60) days from approval date. ** Form Updated 12/03 **

MAIL CLAIMS TO: P.O. BOX 4590, Oceanside, CA 92052